

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8080 CERTIFICATE OF DEATH

08062

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>3001-4</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELLICOTT CITY</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SHAFFERS CONVALESCENT RETREAT</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>P.</b> Last <b>Becker</b>				4. DATE OF DEATH Month <b>July</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT 16, 1874</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.		IF UNDER 24 HRS. Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>ROSE P. WHIPPERMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>INFORMANT</b>			
				Address <b>BESSIE V. BARNES-1314 WELDON AVE</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO <b>Intermittent Cardiac Vasculature Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5 yrs</b> (c) <b>5 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 4</b> , 19 <b>60</b> , to <b>July 6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>July 4</b> , 19 <b>60</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas F. Herbert</b> M.D.				DATE SIGNED <b>7-7-60</b>			
PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MIDDLETOWN</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO CO MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest E. Donovan</b>				24a. REC'D BY REGISTRAR <b>12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

8084

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Clarksville</b>		c. LENGTH OF STAY IN 1b <b>51 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Clarksville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Philip Joseph Chambers</b>				4. DATE OF DEATH Month <b>July</b> Day <b>22</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/22/09</b>		9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School bus driver</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Richard Chambers</b>				14. MOTHER'S MAIDEN NAME <b>Margie Lord</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-14-8407</b>		17. INFORMANT Address <b>Mrs. Margie Broadwater, Clarksville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery occlusion</b> <b>420-1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Ten min.</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Charles S. Whitaker</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>7/23/60</b>			
EXAMINER'S NAME (Type) <b>Charles S. Whitaker, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-25-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Louis</b>		22d. LOCATION (City, town, or county) (State) <b>Clarksville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

8085

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 8, 9 Film 2677-18-60 et

08064

1. PLACE OF DEATH a. COUNTY <b>Howard</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural -- Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 yr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Underwood Rd. At Forsythe Rd.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural -- Sykesville</b>			
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>C.</b> Last <b>ESWORTHY</b>				4. DATE OF DEATH Month <b>July</b> Day <b>9,</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1912 December 31, 1912</b>	
9. AGE (In years, last birthday) <b>47 yrs.</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>49</b> Hours <b>49</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Yard</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>John A. Esworthy</b>				14. MOTHER'S MAIDEN NAME <b>Frances E. Webb</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. Two 220-09-2165</b>		17. INFORMANT Address <b>Miss. Mary C. Esworthy, Same as 1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma lung, liver &amp; brain</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastases, bronchial pneumonia,</b> DUE TO (c) <b>Cardiac failure rt side, anemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1959 to 9 July 60</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> to <b>9 July 1960</b> , that (I) (we) last saw the deceased alive on <b>9 July 1960</b> , and that death occurred <b>4:00 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Howard E. Hall</b>				22b. DATE SIGNED <b>10 July 60</b>		22c. PHYSICIAN'S NAME (Type) <b>Howard E. Hall M. D.</b>	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>July 11, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>McKendree Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Howard Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>JUL 13 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

(0207)

OFFICE OF THE ATTORNEY GENERAL

8887

RECEIVED

RECEIVED

RECEIVED

10

State of Tennessee, County of Davidson, ss. I, J. W. ...

Understand that the following is the true and correct copy of the ...

Witness my hand and seal of office this 10th day of July, 1907.

John A. ...

Attest: J. W. ...

...

...

...



may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8086

CERTIFICATE OF DEATH

08065

Items 4, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60 et

1. PLACE OF DEATH a. COUNTY <b>Howard</b> b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <b>Simpsonville</b> c. LENGTH OF STAY IN lb <b>Life</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <b>Simpsonville, Md</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>William</b> First <b>Alfred</b> Middle <b>Galloway</b> Last 5. SEX <b>Male</b> 6. COLOR OR RACE <b>Col</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>March 10, 1900</b> 9. AGE (In years last birthday) <b>60</b> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				4. DATE OF DEATH Month <b>July</b> Day <b>24</b> Year <b>1960</b>			
13. FATHER'S NAME <b>Alfred Galloway</b> 14. MOTHER'S MAIDEN NAME <b>Alberta ?</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <b>214-12-7062</b> 17. INFORMANT <b>Mrs. Margaret E. Galloway</b> Address <b>Simpsonville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Nodules</b> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <b>9 Mo</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>11/30</b> to <b>7/24</b> , 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>7/17</b> , 19 <b>60</b> , and that death occurred at <b>1:30</b> M, from the causes and on the date stated above.				22a. SIGNATURE <b>B P Warren</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <b>B P WARREN</b> 22d. ADDRESS <b>Leuch Ind</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/27/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Locust Memorial Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Simpsonville, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert L. Snowden</b> ADDRESS <b>Rockville, Md</b>				25a. REC'D BY REGISTRAR <b>Aug 1 '60</b> 25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
1SM 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8081

## CERTIFICATE OF DEATH

08066

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Howard</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Church Road</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b> d. STREET ADDRESS <b>Church Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <b>William Ernest KRAFT</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>July 31, 1960</b> Month Day Year			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Dec. 12, 1879</b>	
<b>9. AGE</b> (In years last birthday) <b>80</b> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>U.S. Government</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Ellicott City, Md</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>				<b>13. FATHER'S NAME</b> <b>Andrew Kraft</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Dorothy Leimbach</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
<b>16. SOCIAL SECURITY NO.</b> <b>None</b>				<b>17. INFORMANT</b> <b>Dr. Thomas F. Herbert, Church St. Ellicott City</b>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause on line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular disease</b> <b>422.1</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from Feb. 4, 1957, to July 31, 1960, that I last saw the deceased alive on July 30, 1960, and that death occurred at 10:50 P.M. from the causes and on the date stated above.</b> ADDRESS (Street, city or town, state) <b>Ellicott City, Md</b> DATE SIGNED <b>7-31-60</b> ACTUAL SIGNATURE <b>Thomas F. Herbert, M.D.</b> PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D.</b>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>8-3-60</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Johns</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Ellicott City, Md</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>F.C. Higinbotham, Ellicott City, Md</b> ADDRESS				<b>24a. REC'D BY REGISTRAR</b> <b>AUG 2 '60</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Hines</b>	

MEDICAL CERTIFICATION

1880

1880

1880



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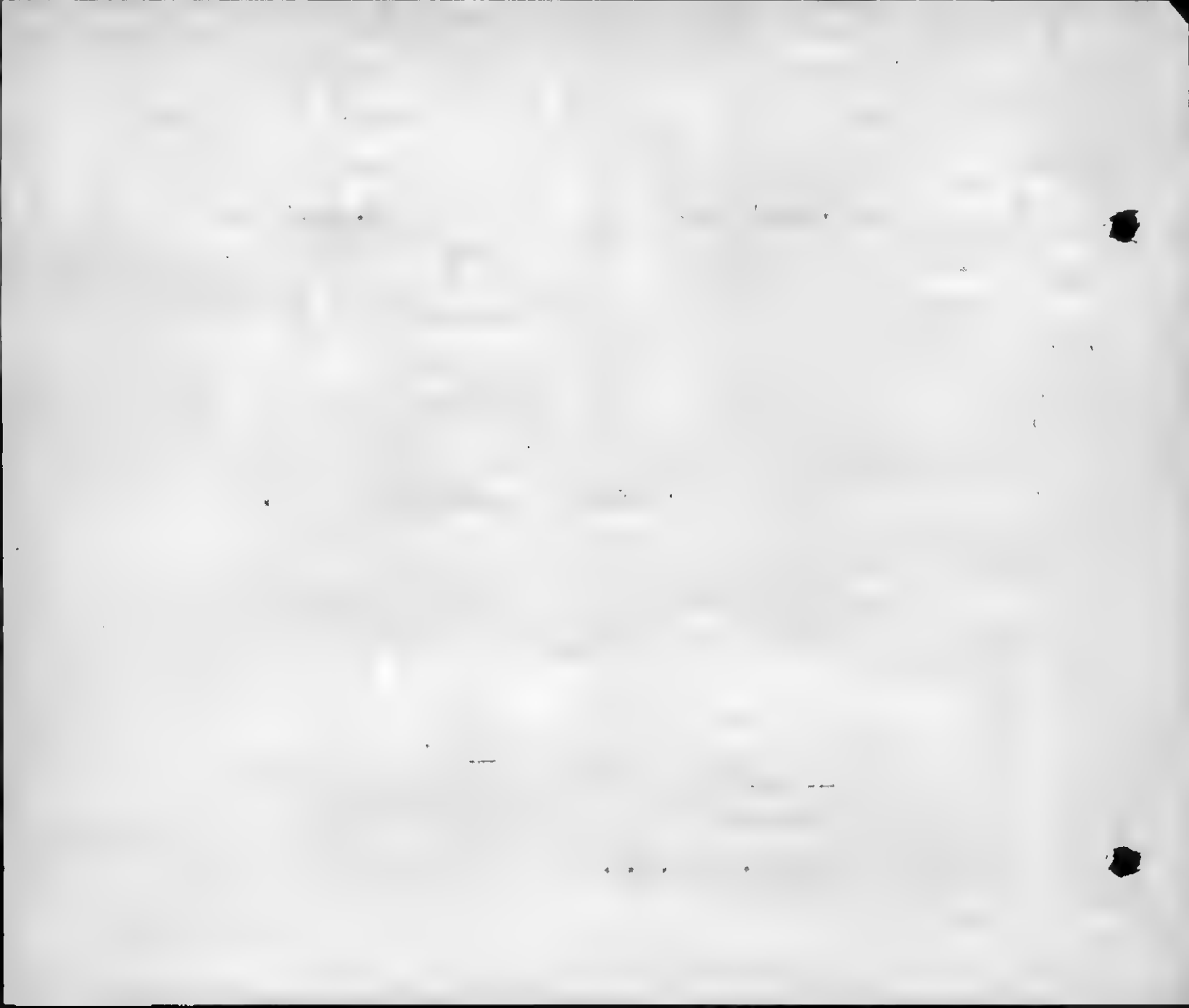
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please indicate the certificate is "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

8082  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Howard</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		c. LENGTH OF STAY IN TB <b>Ellicott City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>47 St. John's Lane</b>		d. STREET ADDRESS <b>47 St. John's Lane</b>	
3. NAME OF DECEASED (Type or print) <b>CHARLES</b>		4. DATE OF DEATH Month <b>July</b> Day <b>23</b> Year <b>19 60</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG 30, 1887</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		10. BIRTHPLACE (State or foreign country) <b>Germany</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker (retired)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-10-67-6</b>	
17. INFORMANT <b>MRS MARGARET NOLTE</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>122.1</b> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D.	
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>		DATE SIGNED <b>7/26/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/26/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS</b>		22d. LOCATION (City, town, or country) (State) <b>Violetville Md.</b>	
23. FUNERAL DIRECTOR <b>Witz KE</b>		ADDRESS <b>4101 Edmondson Ave</b>	
24a. REC'D BY REGISTRAR <b>JUL 27 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

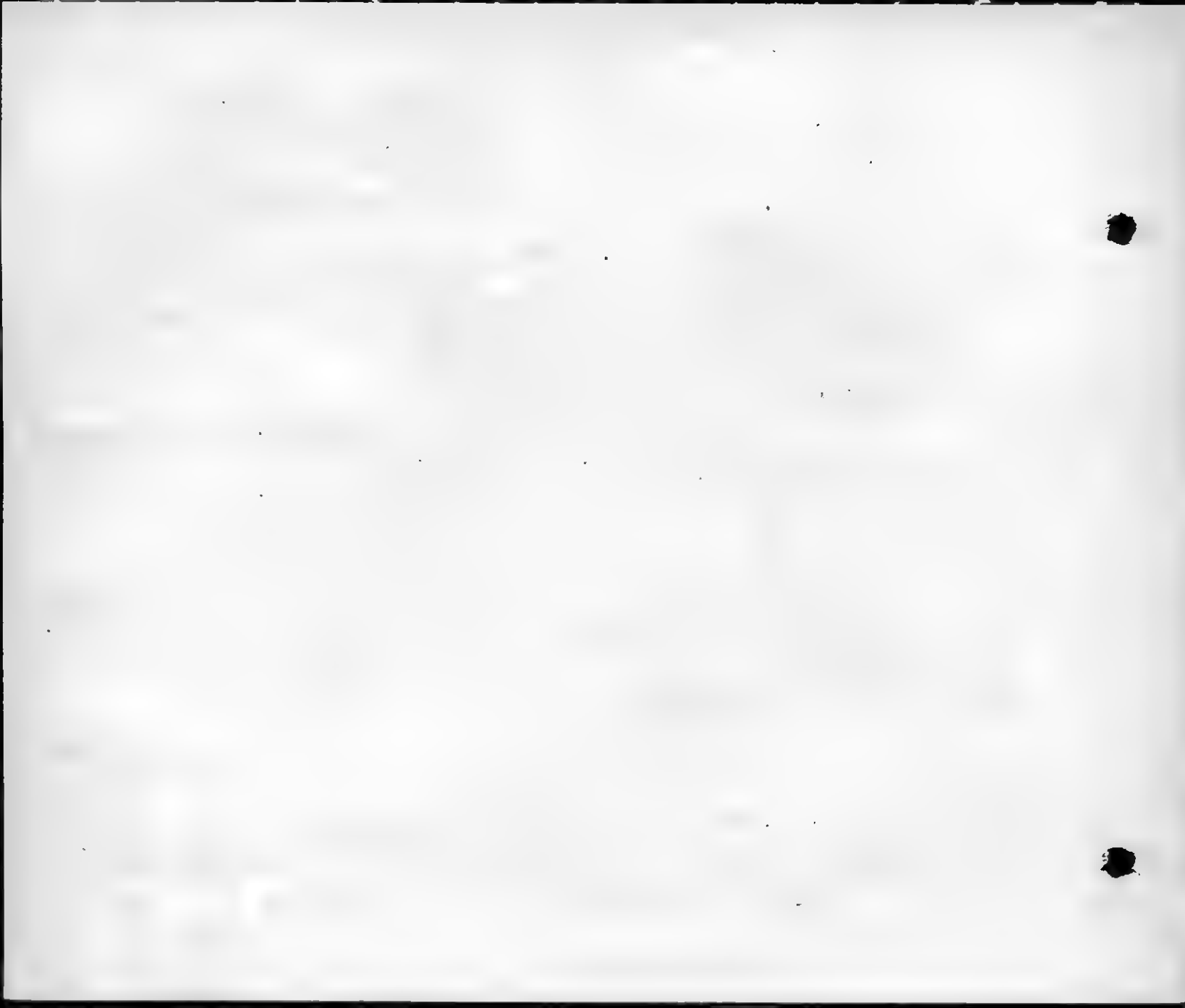
VR A15 (4)  
15M 9/59

8087

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08062

1. PLACE OF DEATH a. COUNTY <b>Howard County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b> c. LENGTH OF STAY IN 1b <b>Elkridge</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Linden Ave.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b> d. STREET ADDRESS <b>621 Southmont Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Selma</b> Middle <b>E.</b> Last <b>Owens</b>		4. DATE OF DEATH Month <b>7</b> Day <b>17</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 --13--1885</b>
9. AGE (In years last birthday) <b>75</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>Henry Eversmier</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Lillian Uebel</b> Address <b>Linden Ave; Elkridge, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic hypertensive cardiovascular disease</b> 4/73 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs +</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from <b>August, 1954</b> to <b>July 17, 1960</b> , that (I) (we) last saw the deceased alive on <b>6-23-1960</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.	
22a. SIGNATURE <b>John A. Nesbitt Jr.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>JOHN A. NESBITT, JR.</b>		22d. ADDRESS <b>1118 St Paul D., Balto 2, Md.</b>	
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7-20-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Salem Lutheran</b>		23d. LOCATION (City, town, or county) (State) <b>Catonsville Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Mac M. Fox-301 Tudor Rd</b>		25a. REC'D BY REGISTRAR <b>DATE JUL 21 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



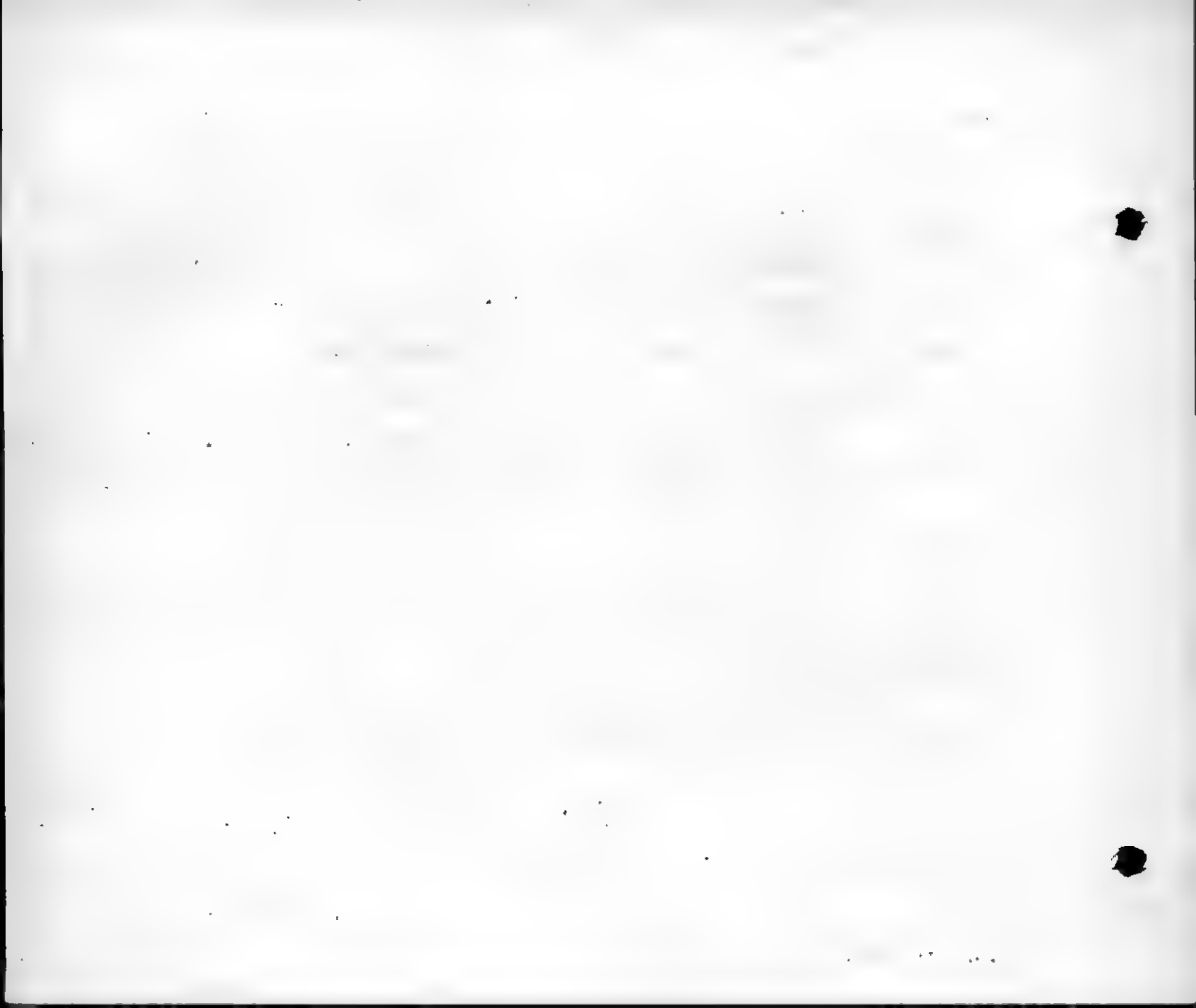


**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**8083**  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **08068**

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b> <b>Howard</b>				2. USUAL RESIDENCE (Where deceased lived If institut an. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>25 Fels Ave.</b>				d. STREET ADDRESS <b>25 Fels Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CORLINE</b> Middle <b>SCOTT</b> Last				4. DATE OF DEATH Month <b>July</b> Day <b>16</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 6, 1905</b>	
9. AGE (In years last birthday) <b>54</b> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Ellicott City, Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>None</b>				13. FATHER'S NAME <b>Samuel Scott</b>			
14. MOTHER'S MAIDEN NAME <b>Carrie Ward</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				INFORMANT Address <b>Mary Jane Houston, 25 Fels Ave. Ellicott City, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>32X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>2-15</b> , 19 <b>59</b> , to <b>7-16</b> , 19 <b>60</b> ; that I last saw the deceased alive on <b>3-8</b> , 19 <b>60</b> , and that death occurred at <b>10:45</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Ellicott City, Md</b> ACTUAL SIGNATURE <b>Thomas F. Herbert</b> M.D. DATE SIGNED <b>7-18-60</b> PHYSICIAN'S NAME (Type) <b>Thomas F. Herbert, M.D.</b>							
22a. BURIAL CREMAT ON, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-20-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Star</b>		22d. LOCATION (City, town, or county) (State) <b>Ellicott City, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>F.C. Higinbotham, Ellicott City, Md</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thoma</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

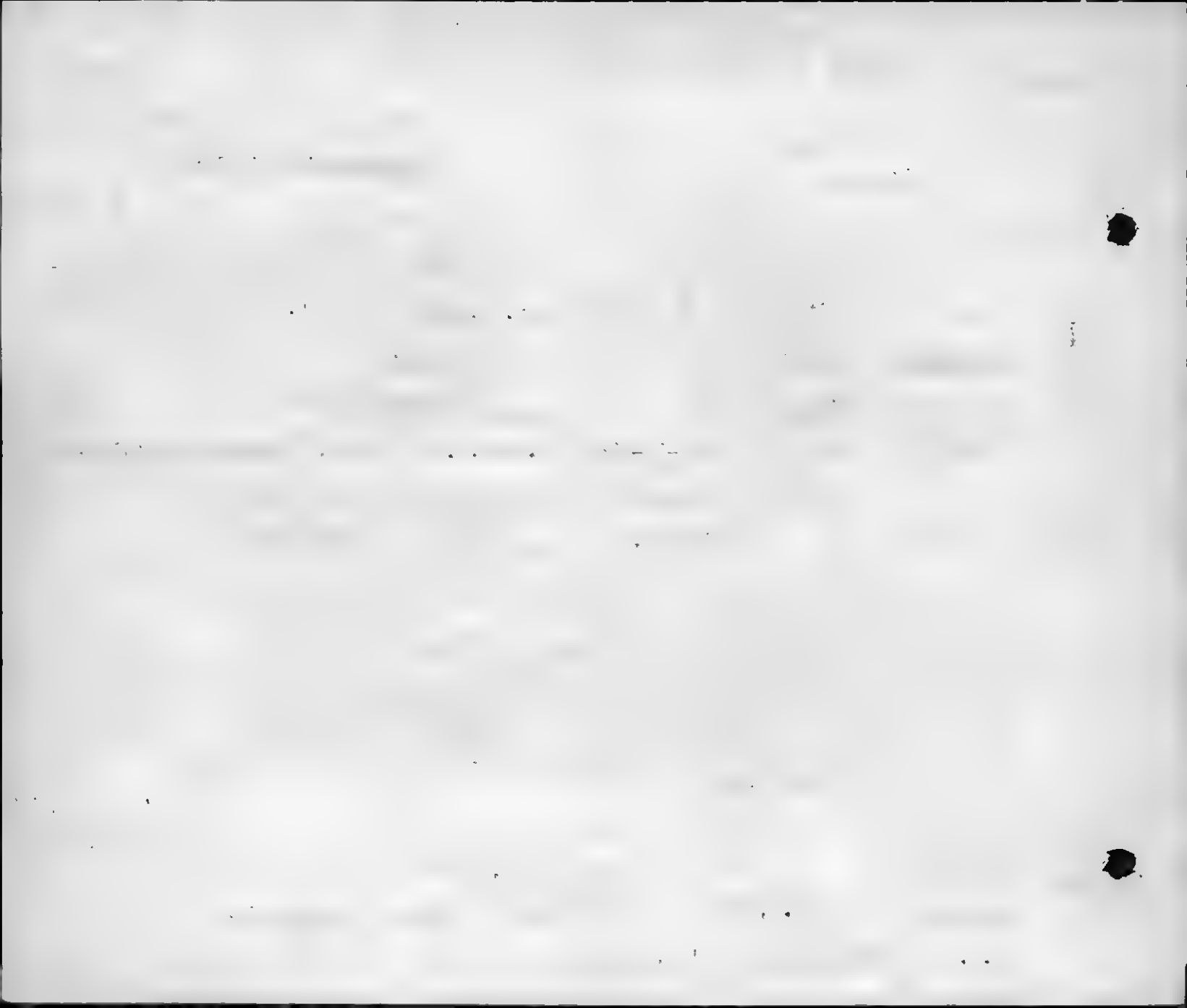


1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If delay is necessary, please advise the certificate, writing the word "penalty" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
8088 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08069

1. PLACE OF DEATH a. COUNTY <b>HOWARD</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Highland</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <del>XXXXXXXXXX</del> <b>Highland</b>			
3. NAME OF DECEASED (Type or print) First <b>Jacob</b> Middle <b>E</b> Last <b>Shillinger</b>				4. DATE OF DEATH Month <b>July</b> Day <b>28</b> Year <b>19 60</b>			
5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <b>Apr. 23, 1890</b>				9. AGE (In years last birthday) <b>70</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Veterinary</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Samuel Shillinger</b>				14. MOTHER'S MAIDEN NAME <b>Teresa Swinghammer</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WW 1</b>				16. SOCIAL SECURITY NO. <b>216-38-7369</b>			
17. INFORMANT <b>Dr. Robt. B. Shillinger, 3A Watkins Acres, Frederick</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic cardiovascular</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>disease.</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a. 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>Partial</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State) <b>PARTIAL</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>W. C. Givens</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DATE SIGNED <b>July 28, 1960</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
<b>Burial</b>				<b>Aug. 1, 1960</b>			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or country) (State)			
<b>Arlington National</b>				<b>Arlington, Va.</b>			
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR			
<b>F.C. Higinbotham, Ellicott City, Md</b>				24b. REGISTRAR'S SIGNATURE			
				DATE <b>AUG 1 '60</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8089

## CERTIFICATE OF DEATH

Reg. Dist. No. 08070

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		c. LENGTH OF STAY IN 1b <u>6.5 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <u>5500 Race Road</u>				d. STREET ADDRESS <u>15500 Race Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nannie</u> First <u>Byrd</u> Middle <u>Taylor</u> Last				4. DATE OF DEATH <u>July</u> Month <u>18</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 21, 1885</u> 75 yrs.	
9. AGE (In years birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Months <u>1</u> Days <u>18</u> Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Caroline Co. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Dolly</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Maria Rideout</u> Address <u>210 Winters Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary occlusion</u> DUE TO <u>Chor Myocarditis</u> DUE TO <u>General Arteriosclerosis</u> DUE TO <u>Parkinson's Syndrome</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Syndrome</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 18, 1960</u> , to <u>July 19, 1960</u> , that I last saw the deceased alive on <u>July 18, 1960</u> , and that death occurred at <u>9:05 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1609 Main St Elkridge Md</u> DATE SIGNED <u>7/18/60</u>							
ACTUAL SIGNATURE <u>B B Brumbaugh</u>		PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/21/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert E. Hutter</u> ADDRESS <u>3035 W. North Ave</u>				24a. REC'D BY REGISTRAR <u>Jul 20 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1901

MASSACHUSETTS

Name of deceased		Sex		Age		Date of death		Place of death	
John Doe		Male		45		Jan 15 1901		Boston	
Cause of death		Disease		Organ		Time		Place	
Heart failure		Myocarditis		Heart		10:30 AM		Home	
Occupation		Education		Religion		Marital status		Previous illness	
Teacher		High School		Catholic		Married		None	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness		Signature of undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of certificate		Place of certificate		Name of registrar		Name of physician		Name of informant	
Jan 16 1901		Boston		John Doe		John Doe		John Doe	



may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8090

08071

1. PLACE OF DEATH a. COUNTY <b>Howard</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>			c. LENGTH OF STAY IN 1b <b>42 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkridge</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>39 Hunt Club Rd.</b>				d. STREET ADDRESS <b>39 Hunt Club Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary E. Terney</b>				4. DATE OF DEATH Month <b>July</b> Day <b>26</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 1, 1879</b>	
9. AGE (In years lost birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>5</b> Days <b>9</b> Hours <b>45</b> Min.		IF UNDER 24 HRS. Hours <b>10</b> Min. <b>45</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Shipley</b>				14. MOTHER'S MAIDEN NAME <b>Mary Cole</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>		17. INFORMANT Address <b>Mrs. Joseph Montley 5107 Westland Blvd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>arterial Hypertension</b> (c) <b>Obesity</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b> <b>5-9 yr</b> <b>10 yr</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 27 1960</b> to <b>July 26 1960</b> that (I) <del>(we)</del> last saw the deceased alive on <b>July 26 1960</b> and that death occurred at <b>11-15</b> M. from the causes and on the date stated above.							
22a. SIGNATURE <b>Bruce B. Brumbaugh</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Bruce B. Brumbaugh M.D.</b>				22d. ADDRESS <b>5609 Main St., Elkridge 27, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>7/29/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Dorsey, Anne Arundel, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ambrose, Inc. 1328 Sulphur Spring Rd.</b>				25a. REC'D BY REGISTRAR <b>DUL 2 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

11/11/11

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